

Proposed Rule
LSA Document #11-318

DIGEST

Amends [405 IAC 1-1-2](#) to replace five years as the maximum amount of time a recipient can be placed on the restricted card program with an initial two year restriction period subject to biennial review and possible continuation of restricted benefits. Effective 30 days after filing with the Publisher.

[IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses](#)

[405 IAC 1-1-2](#)

SECTION 1. [405 IAC 1-1-2](#) IS AMENDED TO READ AS FOLLOWS:

[405 IAC 1-1-2](#) Choice of provider and use of Medicaid card

Authority: [IC 12-13](#); [IC 12-15](#)

Affected: [IC 12-13-2-3](#); [IC 12-13-7-3](#); [IC 12-15-12](#); [IC 12-15-28-1](#)

Sec. 2. (a) The recipient shall have free choice of providers for services provided in the state of Indiana and for services provided outside the state on an emergency basis, except as provided in subsections (b) ~~through~~ and (c). Services to be provided outside the state, except for those out-of-state areas that have been designated by the office of Medicaid policy and planning (office), which are not of an emergency nature, require prior approval of the office.

(b) In the event the office implements a managed care program, the recipient shall select a managed care provider who is responsible for coordinating the recipient's health care needs. If a recipient fails to select a managed care provider within a reasonable time after being furnished a list of managed care providers by the office, the office shall assign a managed care provider to the recipient. A Medicaid recipient may not receive services from a provider other than the designated managed care provider except in the following cases:

- (1) Medical emergencies.
- (2) Where the managed care provider has authorized referral services in writing.
- (3) Where specific services are excluded from coverage under the managed care program.
- (4) Where specific services covered under the managed care program can be accessed through self-referral by recipients, as designated in [IC 12-15-12](#) et seq.

(c) In the event that the office determines that a Medicaid recipient has utilized any Medicaid coverage service or supply at a frequency or amount not medically reasonable or necessary, the office may restrict the benefits available to such the Medicaid recipient for a period of time, ~~not less than two (2) years nor more than five (5) years, sufficient in the opinion of the office, to prevent further abuses,~~ by noting any restrictions on the face of the recipient's Medicaid card. The office may restrict the Medicaid recipient's benefits by:

- (1) requiring that the recipient only receive benefits from the **provider or** providers noted on the Medicaid card, except as specifically approved in advance by the office; or
- (2) prohibiting the recipient from **receiving**:
 - (A) ~~receiving~~ any specific services noted on the card; or
 - (B) ~~receiving~~ services from any specific **provider or** providers noted on the card.

(d) Not later than two (2) years after a Medicaid recipient's benefits have been restricted, the office will review the Medicaid recipient's case and continue the Medicaid recipient's restricted benefits if review of documented services indicates continued misutilization of Medicaid coverage services or supplies. The continued period of restriction will again be for a period of two (2) years, after which the Medicaid recipient's case will be reviewed and the restriction may again be renewed.

~~(d) Any~~ **(e) A** Medicaid recipient ~~whose benefits have been restricted pursuant to~~ **affected by the initial restriction under subsection (c) or continued restriction of benefits under subsection (d)** may appeal such

~~restriction.~~ **the restrictions.** Recipient appeal rights shall be those provided for in 42 CFR as required by [IC 12-15-28-1](#), and the notice and hearing will be in accordance with the requirements of 42 CFR 431.200 et seq. and [470 IAC 1-4](#).

(e) (f) Before providing any Medicaid covered service, each Medicaid provider shall check the Medicaid card of the individual for whom the provider is performing the service. Failure to do so would result in denial of the provider's claim if the individual is not eligible or the service is not authorized. In checking the Medicaid card, the provider must determine all of the following:

- (1) The Medicaid card is valid for the month in which the service is being provided.
- (2) The individual whose name appears on the Medicaid card is the same individual for whom the service is being performed.
- (3) No **restriction or** restrictions appearing on the Medicaid card would prohibit the provider from performing the requested service.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-102; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 249; filed Oct 7, 1982, 3:50 p.m.: 5 IR 2344; filed May 22, 1987, 12:45 p.m.: 10 IR 2280, eff Jul 1, 1987; filed Aug 22, 1994, 10:00 a.m.: 18 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: [20071010-IR-405070311RFA](#)) NOTE: Transferred from the Division of Family and Children ([470 IAC 5-1-2](#)) to the Office of the Secretary of Family and Social Services ([405 IAC 1-1-2](#)) by P.L.9-1991, SECTION 131, effective January 1, 1992.

[Notice of Public Hearing](#)

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